

UNITED CONCORDIA

Please submit claim to: Dental Claims
P.O. Box 69421
Harrisburg, PA 17106-9421

PATIENT SECTION	1. Patient name		2. Relationship to employee self spouse child other				3. Sex m f			4. Patient birthdate mo day year			5. If full time student school city								
	6. Employee/subscriber name First middle last							9. Contract ID #													
	8. Employee/subscriber mailing address City, State, Zip							10. Employer (company) name and address 													
	11. Group Number		12. Location (Local)		13. Are other family members employed? Employee name Contract ID #			14. Name and address of employer in item 13 													
	15. Is patient covered by another dental plan?		Dental plan name		Union local		Group no.		Name and address of carrier 												
DENTIST SECTION	I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment. Signature (patient or parent if minor) Date							I hereby authorize payment directly to the below name dentist of the group insurance benefits otherwise payable to me. Signature (insured person) Date													
	The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, United Concordia may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practices.																				
	16. Dentist name							24. Is treatment result of occupational illness or injury?		No	Yes	If yes, enter brief description and dates									
	17. Mailing address City, state, zip							25. Is treatment result of auto accident?													
								26. Other accident?													
DENTIST SECTION	18. Dentist soc. sec. or T.I.N.							19. Dentist license no.		20. Dentist phone no.		28. If prosthesis, is this initial placement?				(If no, reason for replacement)		29. Date of prior placement			
	21. First visit date current series		22. Place of treatment Office Hosp. ECF Other		23. Radiographs or models enclosed?		No	Yes	How Many?		30. Is treatment for orthodontics?				If services already commenced enter		Date appliances placed				
																	Mos. treatment remaining				
DENTIST SECTION	Identify missing teeth with "X"		31. Examination and treatment plan-list in order from Tooth No. 1 through Tooth No. 32 - Use charting system shown.												Use charting system shown		FOR ADMINISTRATIVE USE ONLY				
			TOOTH NO. OR LETTER		SURFACE		DESCRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.						DATE SERVICE PERFORMED MO. DAY YR.			PROCEDURE CODE		FEE			
I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.														TOTAL FEE CHARGED							
Signature (Dentist) _____ Date _____																					

<u>California:</u>	For your protection California law requires that the following appear on the form: Any person who knowingly presents a false claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
<u>Florida:</u>	Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.
<u>New Jersey:</u>	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
<u>New York:</u>	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
<u>Louisiana:</u>	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
<u>Virginia:</u>	Any person who within the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.
<u>Tennessee:</u>	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.